Department of Veterans Affairs **VHA DIRECTIVE 2006-044**
Veterans Health Administration
Washington, DC 20420 **July 10, 2006**

FISCAL YEAR (FY) 2006 NETWORK ALLOCATION

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides policy and procedures for the Fiscal Year (FY) 2006 Network Allocations and their use. ***NOTE:*** *The President of the United States' budget is the basis for the allocation of funds to VHA Networks. Future adjustments, depending on Congressional action, may be required.*

2. BACKGROUND: The vast majority of the Network Allocations are prepared using a prospective allocation system called the Veterans Equitable Resource Allocation (VERA) system. VERA was implemented in April 1997, and will continue to be used for the FY 2006 Network Allocations.

3. POLICY: It is VHA policy that the process concerning the allocation of funds to Networks is to follow the specific instructions pertaining to programs which have unique funding requirements as found in Attachment A and Attachment B.

4. ACTION

a. **Format**

(1) The FY 2006 Network Allocation is prepared by the VHA Office of Finance (172). Data to populate the Network Allocation is provided by the Allocation Resource Center.

(2) Network Allocations are provided at the Veterans Integrated Services Network (VISN) level. After the Network allocations are approved and transmitted by the VHA Office of Finance, each Network is required to submit its facility-specific distribution with supporting justification to the Resource Management Office (172). The due date for this information is determined each year, based on existing circumstances, and relayed to each Network. Initial fiscal year Network Allocations to facilities are at the discretion of the Networks and must be developed in accordance with the VHA resource allocation principles outlined in Attachment B, paragraph 2. Additionally, each Network needs to establish an appropriate initial contingency reserve based on historical experience.

b. **Instructions.** Attachment A provides Network Allocation line item explanations and general guidelines for their application. Attachment B provides a list of commonly used terms and their definitions.

5. REFERENCES: Office of Management and Budget (OMB) Circular A-11, Part 4.

THIS VHA DIRECTIVE EXPIRES SEPTEMBER 30, 2006

6. FOLLOW-UP RESPONSIBILITY: The VHA Chief Financial Officer (17) is responsible for the contents of this Directive. Questions may be addressed to 202-273-8159.

7. RESCISSION: VHA Directive 2005-026 is rescinded. This Directive expires September 30, 2006.

Jonathan B. Perlin, MD, PhD, MSHA, FACP
Under Secretary for Health

Attachments

DISTRIBUTION: CO: E-mailed 7/10/2006
FLD: VISN, MA, DO, OC, OCRO, and 200 – E-mailed 7/10/2006

ATTACHMENT A

FISCAL YEAR 2006 NETWORK ALLOCATION EXPLANATIONS AND GUIDELINES

1. FISCAL YEAR (FY) 2006 VETERANS EQUITABLE RESOURCE ALLOCATION (VERA)

a. Approximately 84 percent of the three medical care appropriations for Fiscal Year (FY) 2006 will be distributed to the Veterans Integrated Service Networks (VISNs) through the VERA system. The three medical care appropriations are Medical Services, Medical Administration, and Medical Facilities.

b. Funds will be allocated through VERA's ten price case mix model, which includes Basic Care, Complex Care, Research Support, Education Support, Equipment, Non-recurring Maintenance, adjustments for geographically affected prices, high-cost patients, and a minimum 1.5 percent increase on network allocations above FY 2005 allocations.

c. The veteran count that is used for the allocations is adjusted to reflect the location of the care given. Each veteran's care is pro-rated among the VISNs, which are expected to participate in their care. This pro-ration technique is referred to as Pro-Rated Persons (PRPs).

d. The pool of resources allocated by VERA consists of resources for all activities included in the FY 2006 network allocation, affected by the rate of change in the three medical care appropriations, plus additional programs listed in subparagraph 3l of this Attachment that have been moved from Specific Purpose to General Purpose for FY 2006. ***NOTE:*** *The Veterans Health Administration (VHA) Central Office ordinarily will not supplement these resources during the year; therefore, VISNs must plan accordingly.*

e. The VHA Office of Finance, via the Allocation Resource Center (ARC), distributes additional supportive reports in conjunction with the FY 2006 Network Allocation that provides details for the allocation process and performance data that could be of assistance in maximizing Network resources.

f. **Basic Care.** A distinction between the vested patient and the occasional health care user was made for the FY 2000 Network Budget Allocation process. The Department of Veterans Affairs' (VA) goal was to determine what constitutes a vested patient, even with one visit, and fund those patients at the Basic Care price. A description was needed for the limited user that was not based on the number of care encounters (clinic visits and/or medical facility stays). As a result, beginning in FY 2000, VA decided that Basic Care patients consist of two groups: vested, those who rely on VA for their care, and non-vested, those who use some VA health care services, but are less reliant on the VA system. A patient is considered vested in the veterans health care system if the patient has used inpatient services, or if the patient received an appropriate, detailed medical evaluation during a defined 3-year period. This is determined through the presence of a Current Procedural Terminology (CPT) code that is inclusive of an appropriate medical evaluation. By applying relevant CPT codes to outpatients seen in FYs 2002, 2003, and 2004, vested patients have been identified for FY 2006.

g. In FY 2003, VERA expanded from three to ten price groups. There are now six Basic Care price groups and four Complex Care price groups. A separate price for each of the six Basic Care price groups has been established in VERA to determine network allocations. For FY 2006, these price groups are:

(1) # 1, Non-reliant Care.

(2) # 2, Basic Medical, Heart, Lung, and Gastrointestinal.

(3) # 3, Mental Health.

(4) # 4, Oncology and Legally Blind.

(5) # 5, Multiple Problem.

(6) # 6, Significant Diagnosis.

h. All enrolled veteran users seen in each VISN over a 3-year period, FY 2002 through FY 2004, are incorporated into the Network's FY 2006 VERA allocation. In FY 2005, Priority Group 8 veterans in Basic Care were included in VERA with Priority Group 7 veterans. Priority Group 8 was not created until October 1, 2002, and because FY 2003 is the base year for the FY 2005 VERA model, FY 2005 was the first year they were included in the VERA methodology. The VERA price groups will continue the separate prices for Priority Groups 7-8 in each of the ten price groups based on their relative cost to Priorities 1-6. VERA has twenty prices, with two in each price group. ***NOTE:*** *The VA Office of Policy and Planning prepares veteran user data.*

i. **Complex Care**

(1) Complex Care funding resources are allocated to each VISN using four Complex Care patient price groups multiplied by the forecasted FY 2006 count of Complex Care patient users for each VISN. For FY 2006, the Complex Care Price Groups are:

(a) # 7, Specialized Care.

(b) #8, Supportive Care.

(c) #9, Chronic Mental Illness.

(d) #10, Critically Ill.

(2) Complex Care patients are defined as the projected number of Complex Care patients that the VISN will care for in FY 2006, based upon historical demand from FY 2000 through FY 2004. In FY 2001, the Complex Care projection methodology changed to delete the veteran population factor from the calculation and the projection is now based on historical experience

and the impact of age. ***NOTE:*** *The VHA Office of Finance prepared the Complex Care patient forecasts.*

j. **1 Percent High-Cost Patients.** For FY 2006, the threshold for the additional allocation to Networks for the top 1 percent high-cost patients increased from $75,000 to $80,000; subject to an upper limit of ten standard deviations above the national average cost for providing that service, i.e., treating specialty and/or clinic costs. Networks will again receive an additional allocation equal to the amount that these costs exceed the threshold.

k. **Funding Floor.** This element provides that Networks will receive a minimum 1.5 percent allocation increase above the final amount received in FY 2005. To increase those Networks below a 1.5 percent increase, a negative adjustment is applied to the allocations of all Networks with increases above the national average increase.

l. **Patient Classification Hierarchical Changes**. No change.

m. **Geographic Price Adjustment.** Each VISN's allocation will be adjusted by a labor adjustment that represents its cost of labor relative to the national cost of labor. The labor adjustment will be a zero-sum adjustment at the national level, and is applied to a measure of labor dollars, which, for FY 2006, is the normal pay for the most recent four pay periods in FY 2005 that are accessible and verifiable to the ARC. In FY 2000, the geographic salary adjustment was changed to adopt the labor index methodology recommended by PricewaterhouseCoopers Limited Liability Partnership (LLP) in the VERA Assessment Final Report. This methodology differs from the previous methodology in that it uses a national market basket approach in the formula to create the index, instead of Network-level staffing patterns. By using national data, the index formula does not inter-mingle staffing and salary variables. Therefore, the index is generated based upon specific differences in labor cost. The PricewaterhouseCoopers LLP methodology refines the computation of the labor index to include data related to salary and not Network staffing patterns, producing a pure price index. This national market basket approach reflects the differences in geographic pay without introducing local staffing issues. In FY 2001, the patient factor for computing the labor index was changed to weight Complex Care patients approximately ten times more heavily than Basic Care patients in the application of the geographic price adjustment to account for greater staff intensity for more complex patients. Beginning with FY 2002, and continuing through FY 2006, the labor index is applied to the cost of contracted labor and non-labor contracted goods. These adjustments account for expenses caused by geographic cost factors that are beyond a Network's control.

n. **Research Support Funding.** Research support funding is established for each VISN using a nationally-defined pool of resources and a nationally-defined algorithm. Research support resources are based on the estimates for Medical Care support to research as submitted in the President's FY 2006 Medical Programs Budget Request. The research algorithm distributes resources using a national rate per VA and non-VA funded research. VA and non-VA funded research resources were determined by the Office of Research and Development beginning with FY 2002. In FY 2006, the allocation factor for the distribution of the Research Support funding continues to reward VA-administered Research. The allocation factor for the

Research Support component credits VA-administered research at 100 percent; non-VA funded, non-VA administered, peer reviewed research at 75 percent; and other non-VA funded, non-VA administered, non-peer reviewed research at 25 percent. For FY 2000, the Acting Under Secretary for Health approved the recommendation that Networks 'pass through' the research support VERA allocation as it is computed for each medical center 'Care Line,' or 'Product Line.' Each medical center must explicitly obligate and account for VERA research support funds allocated to support the salaries of researchers, research facilities, and administrative costs. This facility level allocation occurs again in FY 2006, as VHA continues the policy to pass the VERA research support allocation to the medical centers. Networks must again provide a report that justifies any variances from the assigned research support allocations by facility.

o. **Education Support Funding.** Education Support funding is established for each VISN using a nationally-defined pool of resources and nationally-defined algorithm. Education support resources are based on the reported amounts of expenditures for Medical Care support to education as estimated in the President's FY 2006 Medical Programs Budget Request. The education support algorithm distributes resources using a national rate per resident position. Resident positions are those positions distributed to each VISN by the Office of Academic Affiliations for the academic year 2005-2006.

p. **Equipment Funding.** In FY 1997 and FY 1998, Equipment funding (Object Class 31) was based on clinical complexity data (weighted score of 50 percent), unique patient count by Network (weighted at 25 percent), and the Consolidated Memorandum Receipt (CMR) historical purchase rate as a measure of current equipment (weighted at 25 percent). Beginning in FY 1999, the equipment funding was changed to recognize the need to fund patients, not facilities, and gradually phase equipment funding into the VERA Basic and Complex Care elements. The equipment-funding algorithm was revised to use the number of Basic and Complex Care patients for each Network as the distribution factor. The equipment funding revision was phased in over a 2-year period. In FY 1999, 50 percent of the difference between the equipment funding methodology in FY 1997, FY 1998, and the revised method in FY 1999, was used to allocate equipment funds to Networks. Beginning with FY 2000, and continuing through FY 2006, the equipment allocation is based totally on the number of Basic and Complex Care patients.

q. **Non-recurring Maintenance and Repair (NRM).** In FY 1997 and FY 1998, NRM funding (Object Class 32) was based on 90 percent of the Boeckh (square footage) Index and 10 percent on the national pricing pool of funding. In FY 1999, the NRM funding was changed to fund patients, not facilities, and adjusted for differences in regional construction costs. This was accomplished by using the number of Basic and Complex Care patients for each Network, and the portion of the Boeckh Index that adjusts for the cost of construction; phasing this in over 3 years in equal increments by adding 33 percent of the difference between the NRM methodology in FY 1997 and FY 1998, and the revised method in FY 1999, 66 percent in FY 2000, and 100 percent in FY 2001. Beginning with FY 2001, and continuing through FY 2006, the NRM allocation is based totally on the number of Basic and Complex Care patients, with an adjustment for differences in regional construction costs.

2. NETWORKS TO FACILITIES ALLOCATION. The allocation of resources at all levels within VHA needs to be guided by principles that move the organization toward accomplishing its system-wide goals and objectives. These principles must be upheld when Networks allocate funds to facilities or programs. However, due to significant differences in local health care environments, Networks cannot be expected to uphold allocation principles using the same allocation methodology.

a. Among the factors that significantly affect local health care environments are:

(1) Size, mission, and location of facilities.

(2) Levels of affiliations with academic institutions.

(3) Efficiency of operations.

(4) Proportions of shared patients.

(5) Patient complexity and case mix.

b. In developing its allocation to facilities, the following principles are used. The allocation must:

(1) Be readily understandable and result in predictable allocations.

(2) Support high-quality health care delivery in the most appropriate setting.

(3) Support integrated patient-centered operations.

(4) Provide incentives to ensure continued delivery of appropriate Complex Care.

(5) Support the goal of improving equitable access to care and ensure appropriate allocation of resources to facilities to meet that goal.

(6) Provide adequate support for the VA's research and education missions.

(7) Be consistent with eligibility requirements and priorities.

(8) Be consistent with the Network's strategic plans and initiatives.

(9) Promote managerial flexibility (e.g., minimize "earmarking" funds) and innovation.

(10) Encourage increases in alternative revenue collections.

c. The following information must be submitted in the following order to the VHA Office of Finance (172) after a Network receives its General Purpose allocation. The due date for this

information is determined each year, based on existing circumstances, and relayed to each Network. In providing this information Networks must:

(1) Provide a facility-specific quarterly distribution of its budget to the Resource Management Office (172B3) for input into the Automated Allotment Control System (AACS).

(2) Identify and briefly describe the approach used to allocate its funds to facilities, to include a:

(a) Modified version of VERA-Capitation.

(b) Building upon the facilities' FY 2005 budgets.

(c) A combination of (a) and (b).

(d) Other (explain).

(3) Briefly describe how its allocation model adheres to each of the allocation principles outlined in subparagraph 2b of Attachment A.

(4) Briefly describe its Network reserve in terms of size, rationale for allocation to facilities, and expected release timing.

(5) Briefly explain how its allocation process ensures equity as defined in Public Law 104-204 (i.e., to ensure that veterans who have similar economic status and eligibility priority and who are eligible for medical care have similar access to such care).

3. MEDICAL CARE PROGRAM NOTES

a. The Three Medical Care Appropriations

(1) Beginning in FY 2004, Public Law 108-199, the Consolidated Appropriations Act, 2004, directed that the Medical Care appropriation be divided into three separate appropriations.

(a) Medical Services (36_0160). Medical Services is for direct patient care.

(b) Medical Administration (36_0152). Medical Administration is for management and administration of the VA health care system and medical program information technology personnel services, travel, and training. Beginning in 2006, Public Law (Pub. L.) 109-114, the Military Quality of Life and Veterans Affairs Appropriations Act, 2006, established the Information Technology (IT) Systems appropriation. The non-pay information technology funding for VHA previously in the Medical Administration appropriation was realigned to the IT Systems appropriation in FY 2006.

(c) Medical Facilities (36_0162). Medical Facilities is for the maintenance and operation of hospitals and other structures, either owned or leased, under the jurisdiction of VHA; and for laundry and food services.

NOTE: *More detailed information on this can be found in the Public Law.*

(2) For FY 2006, the Military Quality of Life and Veterans Affairs Appropriations Act is Public Law 109-114. Additional information and guidance on the transition from the single Medical Care appropriation to the three-appropriation structure can be found on the VHA Central Office of Finance Intranet website at: (http://vaww.cfo.med.va.gov/) under the Omnibus Appropriation Bill FY 2004 link.

b. **Full-time Equivalent (FTE) Employment.** In FY 2006, FTE levels will not be assigned during the budget process. Any required accountability and control of supportable FTE will be accomplished at the VISN level. Readjustment Counseling (25), Health Professions Education Programs (26), and other programs with specific FTE are not in the Network Allocation. They will be identified in subsequent funding actions. Adequate personal services should be budgeted to support planned employment levels.

c. **Funding for Specialized Programs.** Programs such as Post-traumatic Stress Disorder, Substance Abuse, and Homeless Veterans, whose workloads are captured in the VERA model are included in the Network Allocations. A portion of the allotments provided in the Network Allocation will be made available to these programs. Additional funding adjustments may be accomplished during the fiscal year. Funds received in addition to the Network Allocation, which are allocated for a specific program, must be used for that program or returned to the VHA Central Office program office that provided them. Local arrangements will not be made to carry over unused Specific Purpose funds

d. **Capital Assets.** Funds identified in the FY 2006 Network Allocation for Equipment and NRM are initially targeted for Object Class 31 and Object Class 32 obligations, as defined in Office of Management and Budget (OMB) Circular No. A-11. As recommended in the Office of the Inspector General (OIG) Report, "Audit VHA Major Medical Equipment Acquisition (Number 5R4-E01-120)" dated September 29, 1995; VISNs are responsible for informing management at VA medical facilities of the availability of funds and for developing a schedule detailing the release of funds for equipment acquisition. While the OIG recommendation is equipment-specific, the underlying concept for the planning and purchasing of equipment applies to both Object Classes 31 and 32.

(1) The allocations for Object Class 31 equipment include: funding for equipment procured for existing facilities, and activations projects. Allocations provided for equipment, while identified as such in the VERA allocation, may be used for expenditures other than Object Class 31.

(2) The allocations for Object Class 32 NRM include: funds for leasehold improvements (build out), emergencies, interim projects that arise during the period, and changes or modifications to approved projects. A contingency or "risk pool" should also be established for

those purposes. Allocations provided for NRM, while identified as such in the VERA allocation, may be used for expenditures other than Object Class 32.

e. **The Health Professions Education Programs (Program 26).** The Health Professions Education Programs (Program 26) include Medical and Dental Residents, Specialized Fellows, Veterans Administration Learning Opportunity Residencies (VALOR), and Associated Health Trainees. The Office of Academic Affiliations (144) allocates funding and FTE for these programs except for the VALOR Program, which is administered by the Health Care Staff, Development and Retention Office (10A2D). If trainee positions cannot be filled, local officials in conjunction with Fiscal Service, need to notify the appropriate office so that the resources can be redistributed according to national needs. ***NOTE:*** *Trainee positions may not be switched between specialties without prior approval from the program office. Only Program 26 funds administered by the Office of Academic Affiliations can be used to fund Health Professions Trainees.*

f. **The Employee Education Programs (Program 27).** Effective with FY 1999, Employee Education funds, except funds for the operation of the Employee Education System (EES) and faculty travel, were moved into General Purpose for distribution by VERA, or included in the VISN's travel allocation. This includes travel for participant attendance at EES activities, as well as all costs related to Executive Development and Administrative Trainees. Funds for EES staff, programming, operations, and faculty travel will continue to be funded through Specific Purpose.

g. **Non-VA Workload Programs.** Non-VA workload programs include the State Home (Program 24), Community Nursing Home Care (Program 24), Fee Medical, Fee Dental, and Contract Hospital Programs.

(1) Fee Medical, Fee Dental, Contract Hospital, and Community Nursing Home Care, while funded as part of the model, are still considered non-VA workload programs.

(2) The State Home Program continues to be funded through Specific Purpose funds. Restrictions apply to the funding and the workload. If the actual census for any state home category varies from the assigned level, the program office must be contacted to make the appropriate adjustments to workload and funding levels.

h. **Employee Travel (Limitation .001).** Effective FY 2005, obligations for employee travel will be incurred under Financial Management System (FMS) Fund A1.

(1) **General Purpose.** This allocation is provided to cover normal facility-directed employee travel requirements. This includes travel funds for attendance at conferences, employee education, and participant attendance at EES activities.

(2) **All Other.** These allocations are provided for specifically-identified employee travel such as Readjustment Counseling.

i. **Prosthetics.** For FY 2006, the prosthetics budget continues to be centrally funded and funding for repair (BOC 2551-52) and purchase (BOC 2692-93) of prosthetic appliances and surgical implants, and home oxygen (BOC 2574 and 2674) will be provided as Specific Purpose funding. VHA Central Office Prosthetics and Sensory Aids Service (10FP) monitors activity and expenditures and makes budget adjustments as required.

j. **Leases.** Leases for field-based National Programs will be supported through Specific Purpose funds provided by VHA Central Office. All other lease expenses, including leasehold improvements (build-outs), will be supported at the VISN level.

k. **Items not Included in Network Allocation**. The VERA budgets provided in the Network Allocation reflect the FY 2006 allocation for all medical care General Purpose requirements except the following:

(1) **Allocations for Reimbursable Costs Collected by VA Facilities.** As indicated in the OMB Circular A-11, funds must be collected from non-Federal sources during the fiscal year the receivable is established to receive credit for reimbursement. This has been modified by Pub. L. 104-262 which says: collections for the sharing of medical resources, Title 38 United States Code (U.S.C.) 8153 and TRICARE intermediaries are budgetary resources in the year they are collected, regardless of when the service was performed. Facilities will receive funding on a monthly basis in arrears for those actual earned and/or collected reimbursable costs recorded in the FMS Standard General Ledger accounts 425F (Federal Receivable-Reimbursements), 425G (Federal Collections- Reimbursements), and 425P (Non-Federal Collections-Reimbursements).

(2) **Allocations for First-and Third -Party Collections Collected by VA Facilities.** Pub. Ls. 99-272, 101-508, and 106-117 provided authority for VA to collect co-payments from, and to bill health insurance companies for, specific services provided to certain categories of veterans. In FY 1997, Pub. L. 105-33 established the Medical Care Collections Fund (MCCF). Pub. L. 106-117, signed November 30, 1999, directs these collections be returned to the collecting facility. Pub. L. 108-199, the Consolidated Appropriations Act, 2004, and Pub. L. 108-447, the Consolidated Appropriations Act, 2005, requires receipts from other collections accounts to be deposited into the MCCF beginning in FY 2004. As a result of these two laws, the MCCF receives receipts from the following sources: first-party co-payments, pharmacy co-payments, third-party insurance payments, enhanced-use collections, long-term care co-payments, Compensated Work Therapy Program collections, Compensation and Pension Living Expenses Program collections, and Parking Program fees. Pub. L. 109-114, the Military Quality of Life and Veterans Affairs Appropriations Act, 2006, section 215, states, "That such sums as may be deposited to the Medical Care Collections Fund pursuant to section 1729A of Title 38, United States Code, may be transferred to "Medical services," to remain available until expended for the purposed of this account."

(3) **Permanent Change of Station (PCS).** VHA Central Office funding for PCS is provided for senior management of field-based national programs and resident engineers. All other PCS expenses for field-based national programs are to be absorbed within the funds available to the program activity. Funds are provided in accordance with VA and Federal Travel Regulations.

Requests for funding must be concurred on by the program offices Chief Officer, or designee, and include the:

(a) Program name.

(b) Incumbent's name.

(c) Position being filled.

(d) Reporting date.

(e) Itemized costs for salary.

(f) Travel.

(g) All other.

l. **Items Included in the Network Allocation**

(1) **Franchise Fund Activities.** Franchise Fund Activities include:

(a) VA Records and Vault Storage in Neosho, MO.

(b) Security Office, i.e., background investigations.

(c) Law Enforcement Training Center, in-service training.

(d) Law Enforcement Training Center, resident training.

(e) Austin Automation Center, time share access.

(f) Austin Automation Center, consolidated co-payment processing for first- party collections.

(g) Austin Automation Center, lockbox for first-party debt remittance.

(2) **Medical Care Cost Recovery.** Medical Care Cost Recovery includes:

(a) Area Directors.

(b) Ft. Meade and/or Ellsworth.

(c) Multi-media development.

(d) Communications service.

(e) Integrated Data Communications Utility (IDCU) Digital Equipment Corporation (DEC) Veterans Health Information System and Technology Architecture (VistA) Hardware Maintenance Contract.

(3) **Effective in FY 1999,** the following items, previously funded by Specific Purpose were shifted to General Purpose for funding from Network Allocations.

(a) Recruitment and retention tuition.

(b) Substance Abuse (Alcohol and Drug Halfway House).

(c) College of American Pathologists.

(d) Administrative trainees.

(4) **Effective with FY 2000,** the following items, previously funded by Specific Purpose, were shifted to General Purpose for funding from Network Allocations:

(a) VISN Support Service Center.

(b) Contract Hospital, Brooke Army Medical Center Sharing Agreement, and the Canadian Fee Program.

(c) Leases for Locally-directed Research Activities. Leases for locally-directed Research activities located at Charleston, SC; Manchester, NH; Palo Alto, CA; Honolulu, HI; San Diego, CA; and Cleveland, OH; was moved from Specific Purpose to General Purpose through a 2-year phase in: FY 2000 at 50 percent of the FY 1999 funded level, and FY 2001 at 100 percent.

(d) Prepayment Audit of Transportation Claims performed by Austin Finance Center.

(5) **Effective with FY 2001,** the following items, previously funded by Specific Purpose were shifted to General Purpose for funding from Network Allocations. Homeless Initiatives. The FY 2000 budget included funding for the Homeless Providers Grant and Per Diem; Outreach and Community-based Contract Residential Care; Compensated Work Therapy; Stand Down; Excess Equipment and Clothing Distribution; Program Monitoring and Evaluation; and Multifamily Transitional Housing programs. These programs were funded through Specific Purpose. Beginning in FY 2001, the Outreach and Community-based Contract Residential Care, Compensated Work Therapy, and Stand Down programs were shifted to General Purpose.

(6) **Effective with FY 2002**. No items were identified for FY 2002.

(7) **Effective with FY 2003**, the following items, previously funded by Specific Purpose, were shifted to General Purpose for funding from Network Allocations:

(a) Leases. All Mega Leases were moved from Specific Purpose to General Purpose through a 2-year phase in: FY 2003 at 50 percent and FY 2004 at 100 percent. ***NOTE:*** *This was approved by the National Leadership Board on July 10, 2002.*

(b) Geriatric Research Education and Clinical Care (GRECC). In FY 2003, only the Birmingham-Atlanta, Tennessee Valley Healthcare System (HCS) (Nashville, TN), and Bronx, NY GRECCs were funded through Specific Purpose. The Cleveland and Pittsburgh GRECCs were funded by the VISN in FY 2003 and thereafter.

(8) **Effective with FY 2004.** The following item, previously funded by Specific Purpose was shifted to General Purpose for funding from Network Allocations: GRECCs. In FY 2004, only the Birmingham-Atlanta and Bronx, NY GRECCs were funded through Specific Purpose. The Cleveland, Tennessee Valley HCS (Nashville), and Pittsburgh GRECCs were funded by the VISN in FY 2004 and thereafter.

(9) **Effective with FY 2005.** The following item, previously funded by Specific Purpose was shifted to General Purpose for funding from Network Allocations: GRECCs. In FY 2005, only the Bronx, NY, GRECC will be funded through Specific Purpose. The Cleveland, Tennessee Valley HCS (Nashville), Birmingham-Atlanta, and Pittsburgh GRECCs will be funded by the VISN in FY 2005 and thereafter.

m. **Federal Employment Compensation Payment.** The Federal Employment Compensation Payment (FECP), decentralized beginning in FY 1996, continues to be funded from General Purpose funds and obligated at the medical center level. The initial costing of the FECP obligation is charged to cost center 8401 (Office of the Director). However, FECP is a cost of doing business that will be transferred from 8401 to the respective cost centers where the individuals generating the FECP charges are journalized.

ATTACHMENT B

FISCAL YEAR (FY) 2006 NETWORK ALLOCATION GLOSSARY OF TERMS

1. Administrative Subdivision of Funds. An administrative subdivision of funds is any subdivision of an appropriation or fund, subject to the provisions of the Anti-deficiency Act, which makes funds available in a specified amount for the purpose of incurring obligations. Under the Department of Veterans Affairs (VA) administrative control of funds, only allotments are considered to be administrative subdivisions of funds. An example of an administrative subdivision of funds (Allotment) is the breakout of funds by activity (department or staff office) within the General Operating Expenses Appropriation. *(Source: VA Manual MP-4, Part V, 1B.04.a.)*

2. Allocation. This term is used in two different ways:

a. It is used restrictively to mean the amount of obligation authority transferred from one agency, bureau, or account that is set aside in a transfer appropriation account (also known as an allocation account) to carry out the purposes of the parent appropriation or fund.

b. It is used broadly to include any subdivision below the sub-allotment level, such as subdivisions made by the agency financial plans or program operating plans, or other agency restrictions. *(Source: Office of Management and Budget (OMB) Circular No. A-11.*

3. Allotment

a. Allotment is the authority delegated by the head, or other authorized employee, of an agency to agency employees to incur obligations within a specified amount, pursuant to OMB apportionment or reapportionment action or other statutory authority making funds available for obligation. *(Source: OMB Circular No. A-11.)*

b. It is an authorization by the Deputy Assistant Secretary for Budget to agency heads and staff office directors to incur obligations within specified amounts, during a specified period, pursuant to OMB apportionment or reapportionment action, or other statutory authority making funds available for obligation. An allotment is an administrative subdivision of funds and therefore is subject to the provisions of the Anti-deficiency Act. *(Source: MP-4, Pt. V, Ch. 1, par. 1B.043.)*

4. Apportionment. An apportionment is a distribution made by OMB of amounts available for obligation in an appropriation or fund account into amounts available for specified time periods, programs, activities, projects, objects, or combinations thereof. The apportioned amount limits the obligations that may be incurred. *(Source: OMB Circular No. A-11.)*

5. Appropriation. An appropriation is the authority given to Federal agencies to incur obligations and to make payments from Treasury for specified purposes. An appropriation act, the most common means of providing budget authority, usually follows the enactment of authorizing legislation, but in some cases the authorizing legislation itself provides the budget

authority. *(Source: General Accountability Office (GAO), Accounting and Financial Management Division (AFMD) -2.1.1Budget Glossary.)*

6. Allowance. An allowance is an authorization by department (heads) and staff office (directors) to facility Directors and other officials, of obligation authority, showing the expenditure pattern or operating budget they will be expected to follow in the light of the programs and activities contemplated by the overall VA budget or plan of expenditures. *(Source: MP-4, Pt. V, 1B.04.d.)*

7. Fee Basis

a. Fee basis is a type of contractual arrangement on an individual basis, for an individual situation, for a designated period of time, and authorized via a VA Form 10-7079, Authorization for Fee Outpatient Medical Services; traditionally it has been the responsibility of Medical Administration Services (MAS) at most facilities. Due to mergers, reorganizations, and restructuring, many MAS activities have ceased to exist and responsibility for the program has shifted to other areas of facilities. Use Budget Object Class (BOC) 2562 or 2570. *(Source: Health Administration Service.)*

b. When a non-VA physician is brought into a VHA facility to treat a veteran patient. Use BOC 2561 or 2571.

8. General Purpose Funds. General Purpose Funds are allocated funds based on a methodology using quantifiable workload measures. These funds are provided to the Veterans Integrated Services Networks (VISNs) at the beginning of the fiscal year, generally, without restrictions on how they can be spent.

9. Patient Treated. This term is used in two different ways:

a. In a traditional sense, it is used in computing a measure of work, i.e., the total discharges plus the patients remaining bed status plus the patients remaining non-bed status.

b. More recently , it is used to mean the treatment of a specific veteran, which is also referred to as a unique or unique social security number (SSN).

10. Prorated Person (PRP). PRP is a computation based on the share of a patient's national cost. At the national level, each SSN for whom VA has provided care counts as one PRP. Each VISN, providing care for the individual, is assigned a proportion of the PRP in relation to their share of the costs of care for the individual. *(Source: Allocation Resource Center Web Site.)*

11. Refund. A refund is a repayment of excess payments. The amount is directly related to previous obligations incurred and outlays made against the appropriation.

a. Refunds collected by un-expired annual and multi-year appropriations and un-canceled no-year appropriations are to be deposited to the credit of the appropriation or fund account charged with the original obligation.

b. Refunds collected by expired annual and multi-year appropriations are available for upward adjustments of valid obligations incurred during the un-expired period, but are not recorded.

c. Refunds to canceled annual, multi-year, or no-year appropriations are required to be deposited in miscellaneous receipts in the Treasury. *(Source: OMB Circular No. A-11.)*

12. Reimbursement. Reimbursement is the collection that is received by the Federal government as a repayment for commodities sold or services furnished either to the public or to another government account and that is authorized by law to be credited directly to specific appropriations and fund accounts. *(Source: GAO, AFMD-2.1.1Budget Glossary.)*

13. Specific Purpose. Specific purpose funds are allocated funds distributed to the VISNs or medical facilities over the course of the fiscal year for specific events and activities. The funded levels are determined by the need of the specific event or activity.

14. Unique Patient. A unique patient is an individual patient who can be identified by the presence of a singularly unique SSN. *(Source: Allocation Resource Center Web Site.)*